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ABSTRACT

The governance options matrix is provided to offer a way for state and university policymakers to examine the functioning environments of specific university-owned public teaching hospitals. With it, they can consider the benefits and problems involved with different options for governance. The issues related to the environmental factors affecting teaching hospitals are discussed along with how the assessment of the governance options could affect a hospital's teaching, research, service, and operation. The matrix on governance options for university-owned public teaching hospitals was developed by a small task group specifically to help policymakers define the short- and long-term impact of various government models on the functions of the hospitals. It was made to identity important issues for consideration at the legislative, state, or institutional level. Sixteen questions the policymakers must consider are listed and discussed, and it is further noted that for each of these questions, three basic areas should be explored as a first step, i.e.: Does the issue affect the teaching hospital and its mission? How important is the issue? Would a change in the location of the decision alter the actual decision? With this matrix, all parties affected by or interested in the governance can provide input, and the objectivity of decision makers is increased. Areas affected by the governance structure include quality patient care services, enhanced education and research, and organizational administration. A copy of the matrix with instructions for its use is provided. (SM)

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ASSESSING GOVERNANCE ALTERNATIVES FOR UNIVERSITY-OWNED PUBLIC TEACHING HOSPITALS

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INTRODUCTION

The purpose of this publication is to provide a guide for state and university policy-makers to examine the environment in which a particular university-owned public teaching hospital functions and to assess the pros and cons of various options for governance.

Changes in the way hospital services are reimbursed (particularly for Medicare and Medicaid recipients) and growing competitive pressures on hospitals have created concerns among some university and state officials regarding their teaching hospital's financial status. They are also considering what the impact on the university and/or state would be in the event that the hospital experiences substantial operational deficits. In some states these considerations have led to divestiture or legal separation of the hospital from the university; in other states, pressures for separation are being exerted.

Concern has been expressed that changes in governance of teaching hospitals are being considered without benefit of a thorough assessment of how a change in governance would affect on the missions of both the academic health center and the teaching hospital over the long term. Moveover, there is often a lack of information or an inadequate understanding of the health care delivery system environment in which each teaching hospital must compete. This publication focuses not only on the issues associated with the environmental factors that may affect a particular teaching hospital, but also on how assessing various governance options may affect the teaching, research, and service missions, as well as the operational functions, of a particular teaching hospital.

BACKGROUND

The trend toward university-owned teaching hospitals began in the late Thirties, at about the same time that hospital insurance was introduced. After World War II there was a rapid growth in university-based medical schools and most universities either built or bought their own hospitals. Patient care revenues helped support the clinical education of a wide range of university-based health professions programs. With these changes came the trend toward increased specialization in medical education. Today most medical school graduates enter graduate medical education specialty programs that are largely operated and supported by the patient care revenues generated in the teaching hospitals.

Historically, third-party payers reimbursed hospitals based on charges. Losses in revenues for indigent care were covered by increasing the charges to paying patients. The advent of the Medicare and Medicaid federal insurance programs for the aged and indigent in the late Sixties was accompanied by rapid growth in expenditures for health care. As the costs of health care paid by federal dollars began to erode the availability of funds for other public and governmental services, federal policies were established to restrict reimbursements for health care. By the early Eighties, federal cost containment policies were directed toward competition as a means of slowing the growth in expenditures for health services. Today, Medicare and, in some states, medicaid reimbursement rates for hospital services are a fixed sum based on each patient's diagnosis at admission. Reimbursement rates are established for over 400 Diagnostic Related Groups (DRGs), the hospital is reimbursed for the full sum for a particular DRG. If a patient can be discharged before costs exceed the specific reimbursement sum for a particular DRG, the hospital makes money. However, if a patient must remain in the hospital for an especially long stay or the cost for needed procedures exceed the established DRG rate, the hospital is not reimbursed for the additional costs (except under special circumstances) and therefore loses money.

Cost containment pressures are not limited to the Medicare and Medicaid programs. Competition and the rising costs of health care are changing the way much of our health care is delivered and organized. Many businesses are encouraging their employees to obtain a second medical opinion prior to elective surgical procedures. Many employer-sponsored health insurance programs include financial incentives for employees to use hospital care alternatives, such as outpatient surgical centers, ambulatory care, and home health services. Health Maintainance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are now more common among the health care options offered by employers. HMOs provide a predetermined range of health services on a prepaid basis; PPOs negotiate discounted prices with provider groups (hospitals and physicians) to provide health services for a defined population.

Changes in the economy and public policy have created more poor and near poor who are not insured or are underinsured for health care. This, plus a general decline in hospital admissions and the average length of stay, have stimulated intensified marketing programs among both proprietory and not-for-profit hospitals, seeking to maintain or increase their share of a local or regional market.

In this milieu public hospitals (city, county, or state), and particularly public teaching hospitals, find it necessary to treat an increasing number of uninsured patients; this often results in budget deficits because of unreimbursed care. Another common problem for these hospitals is their inability to acquire the capital necessary for equipment, renovations, and/or expansions needed to continue attracting private paying patients. In addition, hospitals often must compete with other public services for a limited number of dollars; in some states the economy has declined to such an extent that revenue is insufficient to cover the necessary cost of the state Medicaid program for defined indigent patients.

For some teaching hospitals operated by public universities, revenue shortfalls are viewed as a threat to the financial stability of the university. For this reason, and because state rules and regulations often inhibit their teaching hospitals' ability to compete, some state policymakers have moved to separate or divest teaching hospitals from their parent

universities; others are exploring divestiture. Too often, those who are considering changes in governance have been focusing overwhelmingly on the short-term fiscal effects of change rather than the long-term implications of environmental changes and how all of these will affect the service, education, and research missions of both the teaching hospital and the academic health center.

These issues have raised concerns about how to evaluate proposals to change the governance structure of a university-owned public teaching hospital. What are the advantages and disadvantages of such a change?

During a conference sponsored by the Southern Regional Education Board on "State Actions in Health Professions Education" in Oklahoma City in November 1986, it was suggested that SREB, with the assistance of a small group of experts, should develop a matrix system that could be used by universities, their governance systems, statewide coordinating boards, or state governments in their deliberations on governance alternatives for university-owned public teaching hospitals.

In early 1987, a small task group was convened, chaired by Dr. Peter Bosomworth, Chancellor for Medical Center Campus at the University of Kentucky, and a member of SREB's Commission on Health and Human Services. The charge was to develop a matrix on governance options for university-owned public teaching hospitals that could be used by policymakers to define both the short-term and long-term impact of different governance models on the missions, functions, and operational management of these hospitals. The group focused on developing a framework that would enable policymakers to evaluate their own situations. Thus the evaluative process must be sensitive to the unique differences among institutions and states and neutral to assure that the outcome is not influenced.

PURPOSE OF GOVERNANCE OPTIONS MATRIX

The design of the governance options matrix seeks to avoid a conclusion about whether any particular governance structure is better than another. Rather, it emphasizes the identification of those issues that should be considered regardless of whether the analysis of governance of a teaching hospital is taking place at the legislative level, state level, or institutional level. Thus, it is envisioned that this governance options matrix, when used in conjunction with its supporting definitions and instructions, will permit an objective examination of the issues associated with alternative governance models and foster an unbiased assessment of the relative effects of each in a particular situation.

CHANGING ROLES FOR HOSPITAL GOVERNING BOARDS

Traditionally, university-owned public teaching hospitals have been governed by each university's board of regents or trustees. Often these persons have only marginal knowledge of and involvement in the hospital's operations. With increased emphasis on cost containment and the necessity for teaching hospitals to become more competitive, changes have occurred in their role and the governing boards of these hospitals must deal with virtually the same issues as the governing structure of independent not-for-profit and investor-owned hospitals.

Among the roles and functions of teaching hospitals' governing boards are to:

1. Formulate and approve policies
2. Set educational and behavioral standards
3. Consider ethical considerations
4. Review and endorse appointment, termination, and disciplining policies for medical staff
5. Define privileges of medical and other staff
6. Review and endorse types of services and products offered
7. Endorse major operational decisions
8. Review and endorse quality control junctions

9. Review budgets
10. Approve plant/facility expansions and renovations
11. Take part in and endorse fund raising activities
12. Endorse strategic planning
13. Review and endorse marketing programs
14. Approve acquisition of major equipment
15. Approve acquisition of capital
16. Approve subcontracts and joint ventures

The viability of any teaching hospital depends on the extent to which its governing board can function effectively in its environment. In making governance decisions, the roles and functions of an institution's governing structure should be assessed, as these are relevant to the environmental forces in a particular situation.

ENVIRONMENTAL ISSUES RELATED TO THE HEALTH CARE DELIVERY SYSTEM--SHORT- AND LONG-TERM

A teaching hospital's goals and objectives should be established with a thorough knowledge and understanding of the environment and the social and political milieu in which the university-owned public teaching hospital exists. Some of the health care environmental issues are universal, and affect all teaching hospitals, for example, federal Medicare reimbursement policies. Others are localized or peculiar to a state or region, for example, one teaching hospital may find itself serving a large, low income, elderly population while another may have relatively few elderly. *It is because of these differences that a careful analysis of a university-owned teaching hospital's health care delivery system environment is so important prior to any assessment of the pros and cons of the various options for governance. Thus, it is recommended that, prior to using the matrix, an environmental assessment be completed for any institution for which changes in governance are being considered.* This will enable policymakers to identify and understand the full range of issues affecting the health care delivery system in which their hospital operates and will assist in providing protection against bias.

Environmental Assessment

A list of questions follows that policymakers, administrators, and all others who would be directly affected by a change in governance should ask prior to looking at the basic issues associated with a change in governance. These questions may not cover all the environmental issues affecting any one university-owned public teaching hospital, and some may be more important than others in a particular situation. Therefore, for each of these questions and any others that may be raised during an assessment, three basic areas should be explored as a first step in identifying if there is a problem that needs to be solved:

1) Does this issue affect our teaching hospital and its mission?

2) How important is it?

3) How would a change in the location of the decision alter the decision itself.

Questions for Each Institution

1. *Is the teaching hospital's mission clearly defined by all parties, i.e., state policymakers, university board and other officials, medical school administration and faculty, hospital board and the hospital director?*

   American medical education for almost a century has emphasized the integration of education with patient care, complemented by the research findings of outstanding medical scholars. In some academic health centers abundant federal research dollars have shifted the faculty emphasis from medical education to the point that research efforts carry more weight than does teaching or patient care. When large numbers of faculty control substantial research revenues, these faculty are more inclined to perceive the mission of the teaching hospital as that of a laboratory to enhance their research programs. In some centers faculty are facing increasing pressures to treat more paying patients because they are expected to supplement their incomes above and beyond a limited base level paid by the university. These faculty may perceive the mission of the teaching hospital as a clinical facility to generate revenues. In both instances, these perceptions can cause a shift in emphasis from education to research or patient care in a setting in which the major missions of a teaching hospital should be more balanced.

   State and university officials' perceptions of the teaching hospitals' mission may differ. For political or social reasons the teaching hospital may be asked or told by state officials to provide patient care services or programs that do not complement the teaching and research missions of the hospital. The same problem can occur when the teaching hospital is seen by the community as "the indigent care hospital." Paying patients may take their business elsewhere while indigent patients often present limited opportunities for medical students and residents to see a full range of medical problems or to have contacts with patients from all segments of society.

Hospital directors may perceive the teaching hospital's mission as patient care first, with teaching and research secondary missions. Further, the hospital director may place more emphasis on paying patients and improving the hospital's financial status than do the faculty and administration of the medical school. Some difference in the perceptions of the missions of a teaching hospital can be found in virtually every situation; however, where major differences exist, the pressures to divest or separate the teaching hospital from the university may be detrimental to one or more of the major missions of both the hospital and the academic health center. Therefore, one of the most important aspects of evaluating the environment of a teaching hospital is to determine if there are major differences in the perception or reality of its missions among the hospitals' constituencies.

2. *Is the diversification of health care organizations taking place in your area?*

The degree of diversification found is one measure of how competitive a given health care market has become. Hospitals diversify by developing alternative delivery systems, such as HMOs, and by movement into the insurance market. For example, the Voluntary Hospitals of America (VHA) entered into a joint venture with Aetna Insurance Company to offer an insurance package. The venture included teaching and other non-profit institutions representing approximately 12 percent of all acute care beds in the nation. This action occurred after Humana, a national investor-owned hospital corporation, offered health insurance coverage as well as both acute hospital and ambulatory care services. Where public teaching hospitals are unable to implement selected diversification, these hospitals may be at a competitive disadvantage.

3. *Are hospital systems developing and/or expanding in your area? Have these systems addressed the increased demand for long-term care? Can the teaching hospital own, develop, or integrate long-term care into its service continuum?*

Hospital systems have developed through integrating services both vertically and/or horizontally. Multi-hospital systems or consortia, either investor-owned or not-for profit, are generally more competitive due to shared services and their ability to take advantage of economies of scale in marketing and purchasing. Vertical and horizontal integration of hospital systems also increases their competitive edge by offering such a diversified range of services within one system; patients are less apt to be "lost" to other providers. For example, a hospital or a hospital system can vertically integrate by operating a tertiary care hospital, a multi-purpose hospital, a full range of out-of-hospital services, long-term care facilities, and home health services. Horizontal integration may include expanding existing services into neighboring markets or within the same market area. In such an environment a teaching hospital would need the flexibility to participate within existing integrated systems and/or to expand its own operations.

4. *Have there been hospital closures, mergers, or affiliations in your area and if so why?*

Competitive pressures contributed to the closing of over 300 hospitals between 1980 and 1985 in both rural and urban areas. Close scrutiny of the reasons for hospitals having closed can provide insight into the market condition of an area. Similarly, mergers of hospitals can significantly affect the degree of competition in an area.

5. *What changes in information transfer and technology are occurring and what should occur?*

Changes in the way information is transferred, such as computerized patient records, computerized billing, etc. are being initiated between hospitals and other agencies as well as within hospitals.

These changes require capital investments but are generally seen to both improve efficiency and increase the cash flow of hospitals. Changes in technology can mean the need for new sophisticated computers and on-line terminals. The ability to update an institution's information technology--both equipment and personnel to operate it--may greatly enhance a hospital's efficiency, effectiveness, and competitiveness.

6. *How has the professional liability issue affected the teaching hospital and the university? If the teaching hospital were a separate legal entity, what difference would it make for the hospital and/or the university?*

The liability issue has affected all health care providers--some more than others. Where teaching hospitals have residency programs in some of the liability high risk specialties, for example, obstetrics, neurosurgery, orthopedic surgery, the costs associated with liability insurance for residents, if paid by the hospital, add to the already higher costs found in teaching hospitals and affect the ability to compete with other hospitals. However, some public teaching hospitals participate in the state's self-insurance program, which may provide a competitive advantage.

7. *Are all citizens in the area assured access to at least a minimum level of health care services? What are the effects of indigency on access to primary care services, custodial care, organ transplant, etc.? What is the role of the university-owned public teaching hospital in providing access to health services for indigents?*

Many hospitals will accept poor patients who are eligible for Medicaid because they are assured reimbursement for services rendered, even though it generally is not at the same rate as that received for patients having private insurance. However, there are numerous uninsured and underinsured poor who are not eligible for Medicaid insurance coverage. Eligibility criteria will vary from state to state; thus, in any state the criteria for Medicaid eligibility and the economic conditions of an area will dictate the number of poor individuals who are unable to pay for their health care. If the university-owned public teaching hospital is the major provider of health services to the indigent and state support to the teaching hospital is insufficient to offset the losses of uncompensated care, the hospital will experience revenue shortfalls. However, state support to public teaching hospitals can provide a competitive advantage if other hospitals in the area share the responsibility for providing indigent care.

8. *What is the role of the university-owned public teaching hospital in increasing the quality of care in the area?*

A teaching hospital serving as a tertiary care referral center can exert considerable influence on the quality of care provided in an area and add to the knowledge base through its research activities. If this is the role of a teaching hospital, how would it change if the governance of the hospital is changed?

9. *How does the Medicare reimbursement policy affect patient care services and education in the university-owned public teaching hospital? How would this change if governance were changed?*

Medicare reimbursement policies now provide a pass-through reimbursement for some of the indirect education costs associated with Medicare patients in teaching hospitals. In addition, the direct costs of medical education are reimbursed. Medicare has reduced reimbursement for indirect costs and there is some indication there will be some reductions in the level of direct educational costs associated with the provision of care to Medicare patients in teaching hospitals.

10. *What are the predominate forms of reimbursement for the university-owned public teaching hospital (state, federal, private)? How does the teaching hospital compare with other hospitals in the area in forms of reimbursement? What form of governance positions the hospital for the best financial outcome? Will a change in governance remove the hospital from access to university support services? Will it increase the cost of these services, or will the hospital have to replace these services?*

The source and forms of teaching hospital revenues provide insights regarding the population served by the hospital and the hospital's degree of competitiveness. A teaching hospital that receives the bulk of its revenues from private insurers and private paying patients and/or one that operates or contracts with a Preferred Provider Organization (PPO) is likely to be more competitive than one receiving the bulk of its revenues from Medicaid and state appropriations. On the other hand, a university-owned public teaching hospital that has the resources to be competitive may be constrained by state and/or university policies that prohibit the hospital from entering into contractual relationships with other organizations or inhibit the teaching hospital because of a lengthy decision-making structure. A change in governance may deny the hospital access to support services that were historically supplied by the university. Careful assessment of both cash reimbursement to the hospital and in-kind support is necessary to obtain a clear picture of the hospital's financial support structure.

11. *How has the university-owned public teaching hospital been affected by managed care systems in the area? What is their market penetration? Does or can the teaching hospital participate in a managed care system?*

The term "managed care system" can refer to at least three different arrangements. One provides management services for activities such as marketing and computerized billing. A second refers to HMOs where the physicians, either employed by or contracting with the HMO, manage the health services that enrollees of the plan receive. A third, and the most commonly referenced managed care system, refers to PPOs. A PPO may be sponsored by a hospital, a group of physicians, a combination of hospitals and physicians, an insurance company, a for-profit corporation or a foundation. The PPO approaches a company and offers a package of health services for its employees, usually at a discounted price. The employer may encourage employees to use the participating providers through financial incentives such as requiring co-payments when services are not provided by participating providers. The market penetration of managed care systems (HMOs and PPOs) is another index with which to assess the degree of competition in an area. Moreover, teaching hospitals that cannot develop or participate with such systems may be at a disadvantage in capturing their market share.

12. *Are there other academic health centers in your teaching hospital's service area?*

Nearby teaching hospitals may compete with each other for patients, clinical facilities, state funds, endowment and research funds, and other resources. On the other hand, they can complement each other's missions.

13. *What is the dominate pattern for state and/or university administrative controls--delegation or centralization? How are decisions made?*

In some states policies and regulations require that all transactions occur at the state level, sometimes causing increased expense and decreased efficiency. In other states activities, such as purchasing, payroll, selection of architects and engineers, oversight of capital construction, treatment of claims and other responsibilities, are delegated to the university with state accountability maintained through specified policies and auditing. Similarly, some universities have centralized decision making that requires time-consuming procedures; others delegate decision making to those more closely associated with the day-to-day operation of the teaching hospitals. In general, the more centralized the decision-making process is, the less flexibility there is in making decisions. How decisions are made and the timeliness of decisions can affect a hospital's ability to be efficient, effective, and competitive. Some states have made major policy changes that permit timely decision making. Where this has occurred, there is little interest in pursuing divestiture of a teaching hospital.

14. *What is the impact of state government on the university-owned public teaching hospital?*

In general, the more a state supports its teaching hospital the more control it exerts. Where the state, university, and medical school agree on the role and mission of the teaching hospital, strong state support enhances the operation of the teaching hospital. Some state policies, however, inhibit the teaching hospital's operations. For example, in some states the hospital must hire all employees, including professionals, under the state merit system. This process inhibits timely recruiting of qualified staff; and, merit system salary schedules may prevent the teaching hospital from recruiting and retaining the desired professionals. This is particularly significant if other hospitals in the area are offering better salaries, benefits, and other incentives in a market where the supply of qualified professionals is limited.

15. *What is the impact of the university-owned public teaching hospital on the consumer of health care in your area? Would this change and in what ways if the teaching hospital were separated from the university?*

A recent study identified 18 services that were reported unprofitable by a majority of the hospitals in the study (Shortell, 1986). These services were more frequently found among not-for-profit system hospitals than among investor-owned system hospitals. Examples of these services are wellness programs, outpatient psychiatric mental health, disease counseling, education, and hospice care. Where teaching hospitals provide a wide range of health services that are not income generators, a change in governance or management to be more competitive can lead to a decrease in the amount and/or number of these services that are provided by a hospital.

16. *What is the perceived public mission of the university-owned public teaching hospital?*

Each public teaching hospital generates a public and community perception of its mission/s. This may be associated with the population it serves, the types of services provided, and/or the nature and success of its research program. A teaching hospital serving predominantly indigent patients and providing primary and general services would be viewed quite differently from one providing tertiary care services, such as organ transplants, sophisticated cancer diagnostic and therapeutic procedures, burn therapy, invitro fertilization, etc. Sometimes the public's perception of a teaching hospital's missions may be different from the institution's perception of its missions. The board, administration, faculty of the medical school, and the hospital director may see the teaching hospital's missions as focusing equally on education of health professionals, provision of service, and research while the public perceives its principal role to be delivery of patient care services. The public's perception can affect the teaching hospital's ability to compete and it can serve to enhance or hinder change.

DESIGN AND USE OF THE GOVERNANCE OPTIONS MATRIX

Design of the Matrix

The matrix provides a mechanism to solicit input from all parties interested in and affected by the governance of a public university-owned teaching hospital. More importantly, it provides the mechanism for increasing the objectivity of decision makers when deciding what is the best "governance setting" within which to solve the problems identified by a teaching hospital's environmental analysis.

Misunderstandings can be reduced and/or eliminated when all interested parties understand the issues and are provided an opportunity to express their concerns. For these reasons, the matrix has been designed to permit identification of the issues and to focus on a particular situation, regardless of the level--state, regional, or institional--at which an analysis of governance options is taking place.

Alternative Governance Options

The matrix, on its horizontal axis, displays a variety of governance options, including the most common found among university-owned public teaching hospitals. Each structure has advantages and disadvantages; some are unique to particular situations. The general wisdom among those with extensive administrative experience with university-owned public teaching hospitals is that there *is no one best structure*--but a "best structure" can be found for each particular hospital when the environmental issues facing the academic health center and the hospital are addressed and the problem defined. At this point the pivotal question is: What is the problem (or problems) to which a change in governance is the *solution?*

If the problem or problems suggest that a change in governance may be the solution, policy makers should review thoroughly the various facets of each governance option before making a decision. The options for change can include internal restructuring by the university to increase flexibility that may require no actual change in governance. Or, actual governance changes can include arms length divestiture or outright sale of the teaching hospital. It

cannot be over-emphasized that policymakers should focus on the problem. Then the choice for change should depend on finding the best way to solve the problem. A brief description of governance options follows, including information on variations that have been implemented by some universities to improve flexibility and accountability.

Description of Governance Options

I. University Governance

1. University Board--This structure is the most common for state-owned teaching hospitals that are part of a university's academic health center. The university's governing body (a Board of Trustees or Regents) maintain the hospital as a division of the academic health center, subject to state and university policies.

A university's governing board is usually appointed. Members may or may not be from the area serviced by the teaching hospital or have an interest in the operation of the hospital. Administratively, the oversight responsibility for the hospital is most often delegated to the vice president of the academic health center. Some university governing boards have appointed hospital advisory committees, with selected trustees serving on these committees and, in some cases, citizens from the community. The flexibility of university governing boards may be greatly constrained due to university and/or state policies that, for example, would prohibit a university from entering into contracts, hiring non-union or non-merit employees, and other activities that may be relevant to successfully operating a hospital. However, in some states there is a considerable amount of decentralization from the state and university that permits the interdependent components of an academic health center to function more effectively.

2. Auxiliary Enterprise--Auxiliary enterprises within continuing university governance can be established for the purpose of serving the university community, for example, university housing and dining halls.

This option retains the university's governing board and is subject to most of the university financial and management constraints. The board, however, in establishing the auxiliary enterprise can require it to be financially self supporting. Excess revenues generated by the hospital will remain to be used by the hospital (sequestered funds). If the hospital, as an auxiliary enterprise of the university, were to be in financial difficulty, presumably the university board and/or the state would still be required to make a decision about the hospital's fate.

3. Affiliated Corporation--These entities exist primarily to serve the institution and are to be financially self-supporting. Their governance is subordinate to the university's governing board. All university rules and regulations apply with regard to finance and management structure. University athletic associations would be an example.

Universities can create affiliated corporations that function much like wholly owned subsidiaries. Again, this variation focuses on improving the hospital's income by permitting the sequestering of revenues. The flexibility of the affiliated corporation depends on the university board's options and/or willingness to be flexible. Two public universities in the South have established their teaching hospitals as affiliated corporations--the University of North Carolina and the University of Kentucky.

4. Sub-Board--With this structure, the university's governing board maintains control but delegates governance responsibilities to a subordinate board. The degree of authority and autonomy given the subordinate board can vary. They exist to serve the institution and must operate subject to state and university policies.

This variation of university governance can be found at the University of Minnesota. A sub-board's composition is determined by the university board and it can be delegated full authority and autonomy in governing the hospital. Flexibility in this structure again depends on the university board's options and/or willingness to be flexible.

II. Independent Status

1. Not-for-Profit Corporation--This organization has a completely separate governance structure which is not subordinate to the university board of trustees. Educational missions are accomplished through affiliations and contracts. Separate financial, purchasing, personnel, and management systems would exist. Hospital management reports to the hospital board. This option requires an arm's length relationship with the university.

The independent not-for-profit corporation is the most common option selected among those universities electing to separate the teaching hospital from the university. Divestiture of public teaching hospitals to not-for-profit corporations has occurred in Arizona, Florida, Maryland, and West Virginia. This is not a new concept. Most private universities that developed a teaching hospital to be associated with their medical schools, created the hospitals as independent not-for-profit corporations. The term independent, however, is a misnomer in terms of these university's continuing control and influence over the hospital's governance. By design, the bylaws of these corporations establish self-perpetuating boards that often specify that members of the university community serve on the teaching hospital's governing board, i.e., university trustees, the president, vice president for health affairs, dean. In some cases, the president of the university or the chairman of the university's board of trustees is designated to serve as chairman of the teaching hospital's governing board. These arrangements are thought to protect the university and the academic health center's interest in the hospital and to facilitate the teaching and research mission of the hospital. The private universities in the South with independent not-for-profit teaching hospitals serving their academic health center include Johns Hopkins University, Duke University, Emory University, University of Miami, Tulane University, and Vanderbilt University. This governance structure provides the flexibility for a teaching hospital to function in the same manner as any other not-for-profit hospital.

2. For-Profit Corporation--This organization has a completely separate governance structure which is not subordinate to the university board of trustees. Educational missions are accomplished through affiliations and contracts. Separate financial, purchasing, personnel, and management systems exist. Hospital management reports to the hospital board. This option requires an arm's length relationship with the university.

There are no examples of public universities that have elected this divestiture option for their teaching hospital; nor are there any private universities that have created this governance structure for their teaching hospital. There may be state laws or regulations that prohibit a university from divesting state property into an

independent for-profit corporation. It is conceivable however, that a university board could create an independent for-profit corporation with a self-perpetuating board that would adequately protect the university's and/or state's interest in the teaching hospital. This governance structure provides the flexibility common to any independent corporation operating a hospital; however, such a corporation does not have the tax exempt status afforded a not-for-profit corporation.

III. Long-Term Lease or Sale of Teaching Hospital

1. Lease to Not-For-Profit or For-Profit Hospital Chain. This organizational arrangement presents a variety of governance options that cannot be defined easily. Options include participation by university or corporate board, contractual relationships, advisory boards, university dominated local boards, etc.

Theoretically there are multiple governance arrangements that could be negotiated with the lease of a university-owned public teaching hospital. One example of the lease option is the arrangement between the University of Louisville (Kentucky) and Humana, a for-profit hospital chain in which Humana operates the teaching hospital under a lease agreement with the university and the city regarding the hospital's teaching function and its responsibility for providing indigent care. No university-owned public teaching hospital has been leased to a not-for-profit chain.

2. Sale to Not-For-Profit or For-Profit Hospital Chain. Various liaison and contractual relationships exist or could be developed.

There are no instances in which a public university-owned teaching hospital has been sold to either a not-for-profit or a for-profit chain. However, the private church operated Saint Joseph's Hospital, the primary teaching facility for Creighton University (Omaha, Nebraska) Medical School, was sold to American Medical International (AMI).

IV. Local Government, Hospital Authority, or Hospital District

The governance structure for these organizations is completely separate and not subordinate to the university board of trustees. The educational mission is accomplished through affiliations and contracts. Separate financial, purchasing, personnel, and management systems exist. Hospital management reports to a hospital board. This option requires an arm's length relationship with the university.

There are no instances in which a teaching hospital owned by a public university has been separated from the university by divestiture to a local government or a hospital authority. Traditionally, numerous public hospitals owned and governed by local governments as a hospital district or authority also serve as the primary teaching hospitals for nearby academic health centers. Examples are (1 Grady Hospital in Atlanta, Georgia, serving Emory University's Medical School and the Morehouse School of Medicine; 2) Tampa General in Tampa, Florida, serving University of South Florida's Medical School; and; 3) Parkland Memorial Hospital serving the University of Texas Health Science Center at Dallas. Johnson City Medical Center Hospital, a city owned and governed hospital, serves East Tennessee State University College of Medicine, and the Cabell Huntington Hospital, a city-county owned and governed hospital serves Marshall University School of Medicine in Huntington, West Virginia. (A listing by ownership of the principal teaching hospitals for medical schools in the SREB states can be found in the Appendix.)

Areas That May Be Affected by the Governance Structure of A University-Owned Public Teaching Hospital

The matrix, on its vertical axis, presents the areas that may be affected by the governance structure of a university-owned public teaching hospital. The items listed attempt to focus attention on the multiple and often conflicting roles of these hospitals:

1) enhancing the education, research and service missions of the academic health center;

2) providing quality patient care services;

3) administration of a complex business organization in a highly competitive market.

An overview of the areas that can be affected by the governance of a university-owned public teaching hospital follows.

Overview of Issues

University-owned public teaching hospitals were developed with the expectation that the hospital's missions would integrate teaching, research, and service. Some of these hospitals have become tertiary care centers; others serve as the primary source of care for the poor and near poor. With the advent of cost containment initiatives, a surplus of both doctors and hospital beds, and a national aspiration to provide health care under a competitive system, university-owned teaching hospitals with their rather rigid governance structures are finding it more difficult to preserve their triad missions. Before considering a modification of an existing governance structure or separation of the hospital from the university, a thoughtful assessment of how such a change will affect the components of the triad is in order.

The items listed on the vertical axis of the Governance Options Matrix should be assessed in terms of how each of the various governance options (on the horizontal axis) *would affect the missions and the functions of a particular academic health center and its teaching hospital.* The list is not exhaustive nor are the items necessarily mutually exclusive; in fact, many are interdependent.

I. Missions of University-Owned Public Teaching Hospitals. The major missions of an academic health center are: education, research, and service. The public teaching hospital serves as a component of the academic health center and simultaneously as a microcosm of the entire academic health center.

Education. One of the major missions of any teaching hospital is to provide the setting for the clinical education of a multitude of health professions students, i.e., medical, nursing, dental, pharmacy, and allied health students. Both direct and indirect costs are associated with the clinical education of health professions students; some of these costs are supported by patient care revenues and in university-owned teaching hospitals some of the costs are absorbed by the university. In some areas both for-profit and not-for-profit community hospitals have discontinued their clinical affiliations with nearby health professions schools or have levied a charge for access to clinical education. If the university-owned public teaching hospital is the primary source for clinical education for health professions students, how would each of the governance options affect the access to and/or cost of clinical education for public university health professions students?

The types of residency programs operated by a teaching hospital generally reflect the patient care emphasis of the hospital. How will the various governance options change the patient services offered by the university-owned public teaching hospital? Will these changes be consistent with the educational mission of the academic health center and the manpower needs of the state? For example, surgery specialties and subspecialties or medical subspecialties are more lucrative residency programs for many hospitals to operate than programs in family practice or general internal medicine. Yet, the state may be in need of more family practice and general internal medicine specialists than surgical and medical sub-specialists.

Research. Research is an integral component of all universities. Academic health centers pursue research both in the laboratory and in patient care settings. Thus, the university-owned public teaching hospital becomes the clinical research laboratory for its academic health center. These teaching hospitals often have major biomedical research programs regarding the causes, treatment, and prevention of diseases and illnesses. This mission of the hospital could be weakened under certain governance options that focus more on patient care than research or education. This may be evidenced by reduced access to research patients by the hospital, or by negative management attitudes toward research. Under a lease or sale arrangement to a for-profit chain, research may be a secondary objective of the hospital, or the chain may wish to place its research emphasis and funds in one of its other hospitals.

There is also the potential for a loss of revenues to the university if a governance option does not protect patent royalties that may be generated by faculty members' research efforts. Similarly, negotiations with manufacturers for the production of new discoveries could be enhanced or inhibited, depending on the flexibility of the governance structure. The ability to make timely decisions can affect both the revenues and prestige of the university.

Outside funding sources are critical to mounting and maintaining large research programs at any university. The governance structure of the teaching hospital can affect the academic health center's biomedical research grant opportunities. For example, research granting agencies may perceive a for-profit chain as a less appropriate recipient of grant funds than a university-owned or not-for-profit hospital.

Services. The service mission of a university-owned public teaching hospital complements the education and research missions of the academic health center. This includes both patient care services and community services. States often mandate responsibilities to their academic health centers because of the medical care needs of their citizens. For example, an academic health center may be required by the state to provide neonatal intensive care services in its teaching hospital, but the number of premature infants hospitalized may be far in excess of the numbers needed to support the pediatric education programs of the academic health center. Because neonatal centers are high cost and low revenue producers, they are rarely self-supporting. In some instances such centers are state mandated, yet adequate state subsidies are not always provided. In this example, neonatal services complement the educational programs, yet they result in revenue deficits for the teaching hospital. The various governance options may affect the hospital's ability or willingness to accommodate newborn care services or other state-mandated services.

All hospitals over time become perceived in a certain way by their communities and patients. Consideration must be given to how the service goals of a teaching hospital would change under various governance options, and their implications for the community's perception of the hospital. For example, if a public teaching hospital is viewed primarily as an indigent care facility, to select a governance option with the goal to increase the hospital's competitiveness for private patients may not be compatible with the community's perception and subsequent use of the hospital.

On the other hand, a university-owned public teaching hospital serving an indigent population may be able to effectively compete in its market area if it has the flexibility to develop alternative services. These may include outreach services, satellite clinics, ambulatory care centers, contracts with the military or other groups for services, or through shared services with other community hospitals.

In considering various options for governance, policymakers and those involved with the administration of the university, the academic health center, and the medical school, as well as the faculty who are responsible for the service programs of the hospital, *must* carefully consider how each governance option would affect the current and future service missions of the teaching hospital.

II. Funtions of a University-Owned Public Teaching Hospital

Patient care services. The university-owned public teaching hospital has a dual service role. It interrelates with the academic health center in providing one component of its dual service mission and it provides patient care services as an entity, frequently in competition with other hospitals in the area. As such, it is subject to all the laws and regulations that affect its competitors. Yet, the university-owned public teaching hospital may have little control over the kinds of patient services it provides and/or the population it serves. The range and intensity of patient care services provided by a university-owned public teaching hospital is based on a combination of factors. These may include the historical service role of the hospital, the education and research goals of the academic health center, the influence of the medical school's faculty, the degree of competitiveness in the market, and the constraints placed on the teaching hospital by state and/or university policies and regulations.

A teaching hospital may have historically focused on research and high technology services for certain disorders while serving as a major referral center. As more hospitals acquire the capacity to provide high technology services, such a teaching hospital may experience a declining census and an inability to diversify with alternative services if state and or university policies constrain the hospital's ability to be flexible in a changing market. Some teaching hospitals may have selected services such as bone graft or heart transplant centers that were initiated following the academic health center's successful recruitment of prominent orthopedic or cardiovascular surgeons. Some teaching hospitals operate specialized centers in aging, cancer, or mental health, and some provide both contract care and private care. A university-owned public teaching hospital's strong primary care units or long-term care facilities may be associated with its medical school's emphasis on family practice and/or general internal medicine graduate medical education.

The types and scope of patient care services offered can affect a teaching hospitals ability to be competitive and/or fulfill its education and research missions. A change in governance may make a teaching hospital's patient care services more competitive; however, policymakers should carefully assess how the various governance options would affect the hospital's teaching and research missions. *In some instances a change in state and/or university policies and regulations can accomplish the desired results without changing the governance of a public teaching hospital.*

III. Administration of a University-Owned Public Teaching Hospital. In addition to the three major missions of a teaching hospital (education, research, and services) each hospital must carry out multiple administrative functions, including financing, personnel, administration, facility maintenance, purchasing, accountability, and others. These administrative functions are common to all hospitals; however, the manner and the degree to which each can be accomplished are affected by the governance structure of a hospital.

Ability to respond to changing health care delivery system. With the development of large for-profit and not-for-profit multi-hospital systems, prospective payment systems, alternative delivery and managed care systems, public teaching hospitals must be able to be as responsive to constant changes in the health care delivery system as their competitors. The degree of legal autonomy that a teaching hospital has generally affects its flexibility and its ability to meet its teaching, research, and service missions in a competitive environment. For example, a teaching hospital may need to develop out-of-hospital services or long-term care facilities for teaching purposes as well as marketing strategies; yet, state policies may prohibit the hospital from expanding its service base. Similarly, horizontal expansion with satellite clinics or joint ventures with other hospitals may enhance both its teaching and service missions plus increase its market share, but state law may prohibit the hospital or the university from entering into contractual arrangements with non-state entities. If a teaching hospital is unable to develop timely contracts with outside entities or with the faculty practice plan, its ability to foster optimal organizational interrelationships can be inhibited. Therefore, each of the various governance options should be assessed based on how it will affect the teaching hospital's ability to be responsive to a rapidly changing health care delivery system.

Personnel. A university-owned public teaching hospital's personnel policies, wage scale, and fringe benefits are often based on those in effect for all state and/or university employees. When considering governance options it is germane to look at both the advantages and disadvantages of each option for the hospital's employees. Personnel sometimes resist change, and many staff members may be reluctant to give up known benefits, pensions, and rights for the unknown of a new governance structure. Most hospitals that have been divested have been cautious to assure job security and continuity for employees. A teaching hospital's personnel policies can be vital to the hospital's ability to recruit and retain qualified professional staff. In some states, merit systems have been modified to accommodate the teaching hospitals, however, some public teaching hospitals are chronically understaffed because their merit system pay sales are not competitive with other hospitals.

Capacity to respond to a competitive environment. Because of its dual service role a university-owned public teaching hospital must function as the service arm of the academic health center as well as provide the kinds of patient care services that are common to all hospitals. To maintain fiscal viability, a university-owned public teaching hospital must compete with other hospitals in its service area for insured and private pay patients. If it functions as a primary source of care for the indigent population of a state, it may be subsidized by state and/or local governments for these services. Often such subsidies are insufficient to cover revenue losses from unreimbursed care.

A university-owned public teaching hospital's ability to compete for its market share may be severely constrained by state and/or university policies as well as the manner in which decisions are made. For example, if a university-owned public teaching hospital is required to undergo a lengthy contract process (directed and executed at the state level) to obtain approval to purchase a piece of equipment that a competitor can purchase more rapidly and at less cost, the teaching hospital is less effective and less efficient. Moreover, during the delay the teaching hospital loses needed revenues. Similarly, the ability to make timely decisions regarding space, expenditure of funds, and employment of needed personnel will all affect the university-owned teaching hospital's effectiveness and efficiency, and ultimately its competitiveness.

In a competitive environment maximum flexibility is necessary. Both non-profit and investor-owned hospitals are streamlining purchasing policies, participating in multi-hospital arrangements that can offer economies of scale through joint purchasing agreements and/or contracting with HMOs. Updated computerized billing systems provide these hospitals a competitive edge to increase cash flow and to avoid unnecessary delays in reimbursements. Because these institutions are staffed and equipped to readily respond to almost continuous changes in reimbursement policies and procedures imposed by Medicare, Medicaid, and other third-party payers, they are better able to remain competitive. If a university-owned teaching hospital faces decision-making constraints, it will function at a decided disadvantage in a competitive environment.

Ability to contract or earn state appropriations. Most university-owned public teaching hospitals receive state appropriations for a variety of activities. These may include funds earmarked for selected education programs, such as medical and dental graduate education programs, and/or special treatment programs, such as psychiatric services for children, intensive care neonatal services, indigent patient care services, screening programs for disease detection among children from low

income families, and/or special research programs. Policymakers assessing the various governance options should carefully consider the degree to which each of the governance options will affect the teaching hospital's ability to contract for or earn state appropriations for carrying out a variety of public service functions.

Accessibility to funds and capital formation. How well either a not-for-profit or investor-owned business performs on a short-term or long-term basis is integrally associated with its ability to generate, accumulate, and utilize funds. With the growth of cost-based reimbursements, hospitals were pressured to bring cost-accounting practices into line with generally accepted accounting principles. This stimulated the hospital industry to press for clear definitions of reimbursable costs and has led to depreciation being included as a reimbursable cost. Depreciation generates cash flow. It can create reserves and, more importantly, it creates the opportunity for debt. Both not-for-profit and investor-owned hospitals have used debt financing for hospital construction, equipment, and renovation costs. University-owned public teaching hospitals have the same opportunity to generate funds based on depreciation. However, in some states these funds are not controlled by the teaching hospital. They may be used by the university or returned to a state's general fund, leaving the teaching hospital with less flexibility than its competitors because it is unable to manage its depreciation fund balances. Similarly, some university-owned public teaching hospitals are not permitted by state and/or university policies to manage fund balances from operational revenues or interest income. In some states the use of these funds is restricted, also reducing the teaching hospital's management flexibility.

How hospitals acquire capital for renovations, major equipment purchases, and/or major construction is influenced by its governance structure. Investor-owned hospitals can acquire capital funding from the sale of stock, from fund balances in excess of operational expenses, from interest income, and from loans backed by equity. With the exception of revenues from sale of stock, not-for-profit hospitals have the same access to capital funds as investor-owned hospitals plus being eligible to raise capital through the sale of tax exempt bonds. On the other hand, university-owned public teaching hospitals may (depending on state policies) have limited access to capital funding obtained through direct state appropriations from tax revenues or through the sale of state bonds. In this situation a university-owned public teaching hospital must compete for capital funds with all the other public service needs of the state. Sometimes a teaching hospital must delay purchasing equipment or making needed renovations for years until a state's bonded indebtedness level permits the state to issue more bonds.

Another factor that should be explored in assessing governance options is the status of any consolidated education revenue bonds that are related to the teaching hospital. If the university was constructed under a consolidated educational revenue bond, there could be the possibility of a penalty if divesting the hospital would require restructuring such a bond. Yet another issue that must be considered is the method by which assets can be transferred from the university and/or state for any of the divestiture options.

Accountability. In considering the various governance options for a university- owned public teaching hospital it is important to assess how each may affect the hospital's accountability to its various constituencies--the public, the federal government, the state, the purchasers of care, and accrediting and regulatory bodies. Accountability should be assessed from a programmatic and financial perspectives. How will the hospital continue to serve public needs? Will tax funds allocated to the hospital be

restricted for specific purposes, and if so how will the public and elected officials be certain that their mandates are being met? How will the state's and the university's educational interests be assured? What effect will each governance option have on the hospital's accreditation status? What assurances are there that the hospital's licensure status will not be interrupted? These are examples of the kinds of questions that should be asked.

For states that modified the existing governance structure of their teaching hospitals or divested their teaching hospital into not-for-profit corporations, steps were taken to assure programmatic and financial accountability. These include audit requirements, purchasing and contract policies, and specifications for the composition of the governing board. For example, in most cases the composition of the new boards of divested hospitals was specified by the state and or the university. Members may include university trustees, the administrator of the academic health center, and/or other individuals whose position of responsibility and knowledge helped to maintain the interrelationships between the various segments of the university, the academic health center, and the hospital. These interrelationships are critical for a hospital to function in a manner conducive to carrying out the teaching, research, and service missions of both the academic health center and the teaching hospital.

Use of the Matrix

Assuming that the environmental forces affecting the health care delivery system and a particular university-owned public teaching hospital have been assessed, the matrix can be projected against this environment and used as a basis for decisions about what would be gained or lost by changing the governance of the hospital in question.

All parties who may be affected by or responsible for establishing policies that will affect the teaching hospital should be encouraged to participate in reviewing the governance alternatives. Because numbers and word ratings can result in erroneous assumptions about the advantages and disadvantages of a particular governance model, a *color code system is suggested* as a means for gathering information from all parties about their perceptions of how a particular governance structure would affect the multiple roles of the teaching hospital. Assume the following objective for the governance structure of a university-owned public teaching hospital: *The governance structure of a university-owned public teaching hospital should enable the hospital to carry out its multiple roles in the most efficient and effective manner.* Then, ask all interested and affected parties to assess the governance alternatives by *indicating how each* of the governance options listed on the *horizontal axis* of the matrix would affect the items listed on the *vertical axis* of the matrix in terms of meeting the referenced governance objective. The suggested color code is:

Green--Good (will assist in meeting governance objective)

Yellow---Caution (may be a deterrent in meeting governance objective)

Red--Concern (expect difficulty in meeting governance objective)

Each individual who participates in the assessment should be asked to provide a written explanation about why he or she had reservations or concern regarding a particular governance option. The results of these assessments will provide decision makers a spectrum of the perceptions and concerns that different constituencies may have about each governance alternative and the particular areas that generate the concerns. For example, the same

governance option and item will often be rated differently by the hospital administrator, the medical school dean, the faculty, the vice president for health affairs, the university president, the trustees, or a legislator.

Using the assessment results, decision makers are then prepared to seek further clarification about areas of concern and to determine the best course of action for a particular university-owned public teaching hospital operating in a particular environment and to address both the short-and long-term missions of the teaching hospital.

NOTE: Users of the following matrix are encouraged to review this entire report prior to assessing the governance alternatives.

GOVERNANCE OPTIONS MATRIX:
ASSESSING GOVERNANCE ALTERNATIVES FOR UNIVERSITY-OWNED PUBLIC TEACHING HOSPITALS

	ALTERNATIVE GOVERNANCE OPTIONS								
	University Governance				Independent Status		Long-Term Lease or Sale		Other
Areas that may be affected by the governance structure of a public teaching hospital	Univ. Board	Auxiliary Enterprise	Affiliated Corp.	Sub Board	Not-for-Profit Corp.	For-Profit Corp.	Lease to Not-For-Profit or For-Profit Hospital Chain	Sell to Not-For-Profit or For-Profit Hospital Chain	Local Government, District, or Authority
I. MISSIONS OF PUBLIC TEACHING HOSPITALS									
1. Education									
- Medical students									
- Residents									
- Continuing education									
- Education for the public									
- Clinical education for other health professions									
- Other									
2. RESEARCH									
- Applied									
- Basic									
- Access to patients									
- Financing									
- Attitude toward									
- Patent policy									
- Economic development									
- Institutional review board									
- Attitude of research-granting agencies									
- Other									

Areas that may be affected by the governance structure of a public teaching hospital	ALTERNATIVE GOVERNANCE OPTIONS								
	University Governance				Independent Status		Long-Term Lease or Sale		Other
	Univ. Board	Auxillary Enterprise	Affiliated Corp.	Sub Board	Not-for-Profit Corp.	For-Profit Corp.	Lease to Not-For-Profit or For-Profit Hospital Chain	Sell to Not-For-Profit or For-Profit Hospital Chain	Local Government, District, or Authority
3. SERVICE/S									
- State mandates									
- Community perceptions									
- Outreach services									
- Military contracts									
- Other contracts									
- Shared services									
- Existing cooperative arrangements and joint ventures									
- Ability to maintain centers of excellence, including those that are not self-supporting									
II. FUNCTIONS OF A TEACHING HOSPITAL									
1. PATIENT CARE SERVICES									
- High technology									
- Other specialized									
- General *									
- Primary care									
- Ambulatory care									
- Satellite clinics									
- Long-term care									
- Other									

* Includes general medical, surgical, and obstetrical services.

Areas that may be affected by the governance structure of a public teaching hospital	ALTERNATIVE GOVERNANCE OPTIONS								
	University Governance				Independent Status		Long-Term Lease or Sale		Other
	Univ. Board	Auxillary Enterprise	Affiliated Corp.	Sub Board	Not-for-Profit Corp.	For-Profit Corp.	Lease to Not-For-Profit or For-Profit Hospital Chain	Sell to Not-For-Profit or For-Profit Hospital Chain	Local Government, District, or Authority
2. INDIGENT CARE - Medicaid									
- Underinsured									
- Uninsured									
3. SPECIAL PROGRAMS - Geriatric centers									
- Mental health center									
- Contract care									
- Private care									
- Other special centers									
4. CLINICAL & LABORATORY SERVICES PROVIDED BY HOSPITALS									
III. ADMINISTRATION OF PUBLIC TEACHING HOSPITAL 1. ABILITY TO RESPOND TO CHANGING HEALTH CARE DELIVERY SYSTEM - Vertical & horizontal integration									
- Hospital relationships									
- Faculty practice plan relationships									
- Joint venture relationships									
- Degree of legal autonomy									

Areas that may be affected by the governance structure of a public teaching hospital	ALTERNATIVE GOVERNANCE OPTIONS								
	University Governance				Independent Status		Long-Term Lease or Sale		Other
	Univ. Board	Auxillary Enterprise	Affiliated Corp.	Sub Board	Not-for-Profit Corp.	For-Profit Corp.	Lease to Not-For-Profit or For-Profit Hospital Chain	Sell to Not-For-Profit or For-Profit Hospital Chain	Local Government, District, or Authority
- Capacity to develop contracts									
- Organizational inter-relationships and control									
2. PERSONNEL ADMINISTRATION - Continuity for employees									
- Job security									
- Benefits									
- Civil service system									
- Pensions									
- Rights									
- Wage scales									
- Incentives									
3. CAPACITY TO RESPOND TO COMPETITIVE ENVIRONMENT - Timeliness of decisions									
Impact on strategical and tactical planning									
Impact on hospital operations									
- Resource management									
Space									

Areas that may be affected by the governance structure of a public teaching hospital	ALTERNATIVE GOVERNANCE OPTIONS								
	University Governance				Independent Status		Long-Term Lease or Sale		Other
	Univ. Board	Auxillary Enterprise	Affiliated Corp.	Sub Board	Not-for-Profit Corp.	For-Profit Corp.	Lease to Not-For-Profit or For-Profit Hospital Chain	Sell to Not-For-Profit or For-Profit Hospital Chain	Local Government, District, or Authority
Money									
Personnel									
- Purchasing systems									
- Ability to contract									
- Joint purchasing									
- Reimbursement system changes									
- Liability									
- Relationships with alternate delivery systems									
4. ABILITY TO CONTRACT OR EARN STATE APPROPRIATIONS FOR TEACHING HOSPITAL - Funds for residency training programs									
- Special education programs									
- Special treatment programs and/or mandated programs									
- Indigent care									
- Special research programs									
- Other									

Areas that may be affected by the governance structure of a public teaching hospital	ALTERNATIVE GOVERNANCE OPTIONS								
	University Governance				Independent Status		Long-Term Lease or Sale		Other
	Univ. Board	Auxillary Enterprise	Affiliated Corp.	Sub Board	Not-for-Profit Corp.	For-Profit Corp.	Lease to Not-For-Profit or For-Profit Hospital Chain	Sell to Not-For-Profit or For-Profit Hospital Chain	Local Government, District, or Authority
5. ACCESSIBILITY TO FUNDS AND CAPITAL FORMATION - Tax exempt bonds									
- Equity									
- Management of interest income									
- Management of fund balances with reference to income generation									
- Assurance that income generated is retained									
- Use of funds									
- Major renovations									
- Major equipment									
- New construction									
- Consolidated education bonds									
- Transfer of assets resulting from change in arrangements									
6. ACCOUNTABILITY - To public									
- To government									
- To state and payers									

Areas that may be affected by the governance structure of a public teaching hospital	ALTERNATIVE GOVERNANCE OPTIONS								
	University Governance				Independent Status		Long-Term Lease or Sale		Other
	Univ. Board	Auxillary Enterprise	Affiliated Corp.	Sub Board	Not-for-Profit Corp.	For-Profit Corp.	Lease to Not-For-Profit or For-Profit Hospital Chain	Sell to Not-For-Profit or For-Profit Hospital Chain	Local Government, District, or Authority
- To purchasers of care									
- To accreditation bodies									
- Other									

SUGGESTED ASSESSMENT PROCEDURE

Assume the following governance objective: The governance structure of a university-owned public teaching hospital should enable the hospital to carry out its multiple roles in the most efficient and effective manner possible.

Each of the governance options listed on the horizontal axis of the matrix should be assessed based on its potential to affect the items listed on the vertical axis of the matrix in terms of meeting the above governance objective. The assessment should be done using the following color codes:

Color Codes:

Green: Good (will assist in meeting governance objective)

Yellow: Caution (may be a deterrent to meeting governance objective)

Red: Concern (expect difficulty in meeting governance objective)

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APPENDIX

Principal Teaching Hospital(s) Serving Medical Schools in SREB States
By Ownership

Medical Schools	Teaching Hospitals	Ownership		
		State	Not-for-Profit Corporation	Other
ALABAMA				
University of Alabama School of Medicine at Birmingham	University of Alabama Hospitals - Birmingham	X		
	Veterans Administration Medical Center - Birmingham			Federal
University of South Alabama College of Medicine - Mobile	University of South Alabama Medical Center - Mobile	X		
ARKANSAS				
University of Arkansas College of Medicine - Little Rock	University Hospital and Ambulatory Care Center - Little Rock	X		
	Veterans Administration Medical Center - Little Rock			Federal
FLORIDA				
University of Florida College of Medicine - Gainesville	Shands Hospital - Gainesville	Divested to Not-for-profit corp.	X	
	Veterans Administration Medical Center - Gainesville			Federal
University of South Florida College of Medicine - Tampa	Tampa General Hospital - Tampa			Hospital District
* University of Miami School of Medicine - Miami	Jackson Memorial Hospital - Miami			
	University of Miami Hospital and Clinic - Miami		X	County
GEORGIA				
* Emory University School of Medicine - Atlanta	Grady Memorial Hospital - Atlanta			Hospital Authority
	Emory University Hospital - Atlanta		X	
* Mercer University School of Medicine - Macon	Medical Center of Central Georgia - Macon			Hospital Authority
Medical College of Georgia School of Medicine - Augusta	Medical College of Georgia Hospital and Clinic - Augusta	X		
* Morehouse School of Medicine - Atlanta	Grady Hospital - Atlanta			Hospital Authority

* Private medical schools

Medical Schools	Teaching Hospitals	Ownership		
		State	Not-for-Profit Corporation	Other
KENTUCKY				
University of Kentucky School of Medicine - Lexington	University Hospital - Lexington	X		
	Veterans Administration Medical Center - Lexington			Federal
University of Louisville School of Medicine - Louisville	Humanna Hospital University - Louisville	Leased to For-profit corp.		
	Veterans Administration Medical Center - Louisville			Federal
LOUISIANA				
Louisiana State University School of Medicine at New Orleans	Charity Hospital at New Orleans-LSU Division	X		
Louisiana State University School of Medicine at Shreveport	Louisiana State University Hospital - Shreveport	X		
* Tulane University School of Medicine - New Orleans	Tulane University Hospital - New Orleans		X	
	Charity Hospital of Louisiana-Tulane Division - New Orleans	X		
MARYLAND				
Johns Hopkins University School of Medicine - Baltimore	Johns Hopkins Hospital - Baltimore		X	
	Francis Scott Key - Baltimore		X	
University of Maryland School of Medicine - Baltimore	University of Maryland Hospital - Baltimore	Divested to Not-for-profit corp.	X	
	Veterans Administration Medical Center - Baltimore			Federal
MISSISSIPPI				
University of Mississippi School of Medicine - Jackson	University Hospital - Jackson	X Managed by for-profit corp.		
NORTH CAROLINA				
* Bowman Gray Medical School of Medicine - Winston-Salem	North Carolina Baptist Hospital, Inc.-Winston-Salem		X	
* Duke University School of Medicine - Durham	Duke University Medical Center - Durham		X	
East Carolina University School of Medicine - Greenville	Pitt County Memorial Hospital - Greenville			County
University of North Carolina School of Medicine - Chapel Hill	North Carolina Memorial Hospital - Chapel Hill	X		

Medical Schools	Teaching Hospitals	Ownership: State	Ownership: Not-for-Profit Corporation	Ownership: Other
OKLAHOMA				
University of Oklahoma College of Medicine - Oklahoma City	Oklahoma Teaching Hospitals - Oklahoma City	X		
* Oral Roberts University School of Medicine - Tulsa	City of Faith Medical and Research Centers - Tulsa		X	
SOUTH CAROLINA				
Medical University of South Carolina School of Medicine - Charleston	Medical University of South Carolina Medical Center - Charleston	X		
University of South Carolina School of Medicine - Columbia	Richland Memorial Hospital - Columbia			County
	William Jennings Bryan Dorn Veterans Hospital - Columbia			Federal
TENNESSEE				
East Tennessee State University College of Medicine - Johnson City	Johnson City Medical Center Hospital - Johnson City			City
	Veterans Administration Medical Center - Mountain Home			Federal
University of Tennessee College of Medicine - Memphis	University of Tennessee Medical Center - Memphis	X		
	University of Tennessee Memorial Hospital-Knoxville	X		
	Regional Medical Center - Memphis		X	
	Veterans Administration Medical Center - Memphis			Federal
* Vanderbilt University College of Medicine - Nashville	Vandebilt University Hospital - Nashville		X	
	Metropolitan Nashville General Hospital - Nashville			City
	Veterans Administration Medical Center - Nashville			Federal
* Meharry Medical College School of Medicine - Nashville	George W. Hubbard Hospital - Nashville		X	
TEXAS				
* Baylor College of Medicine - Houston	Methodist Hospital - Houston		X	
	Harris County Hospital District Hospitals - Houston			Hospital District
Texas A & M University College of Medicine - College Station	Scott & White Memorial Hospital - Temple		X	
	Olin E. Teague Veterans Center - Temple			Federal
Texas Tech University School of Medicine - Lubbock	Amarillo Hospital District - Amarillo			Hospital District
	Lubbock General Hospital - Lubbock			Hospital District
	R. E. Thomason General Hospital - El Paso			Hospital District

Medical Schools	Teaching Hospitals	Ownership		
		State	Not-for-Profit Corporation	Other
University of Texas Southwestern Medical School - Dallas	Parkland Memorial Hospital - Dallas			Hospital District
	University of Texas Health Center at Tyler (chest diseases)	X		
University of Texas Medical School - Galveston	University of Texas Medical Branch Hospitals - Galveston	X		
University of Texas Medical School - Houston	Hermann Hospital - Houston		X	
	University of Texas M. D. Anderson Hospital and Tumor Institute - Houston	X		
University of Texas Medical School - San Antonio	Bexar County Hospital Division - San Antonio			Hospital Division
	Audie L. Murphy Memorial Veterans Hospitals - San Antonio			Federal
VIRGINIA				
* Eastern Virginia Medical Authority Medical Center - Norfolk	Medical Center Hospitals - Norfolk		X	
	Veterans Administration Medical Center Naval Hospital - Portsmouth			Federal
Medical College of Virginia - Richmond	Medical College of Virginia Hospital - Richmond	X		
	Hunter Holmes McGuire Veterans Administration Medical Center - Richmond			Federal
University of Virginia Medical School - Charlottesville	University of Virginia Hospitals - Charlottesville	X		
	Veterans Administration Medical Center - Salem			Federal
WEST VIRGINIA				
West Virginia University Medical School - Morgantown	West Virginia University Hospital - Morgantown	Divested to Not-for-profit Corp.	X	
Marshall University School of Medicine - Huntington	Cabell Huntington Hospital - Huntington			City-County
	Veterans Administration Medical Center - Huntington			Federal

42 medical schools in region; 13 private, 29 public

There are 18 state-owned teaching hospitals among the 29 public medical schools, of which two (in Texas) are specialized. The University of Tennessee has 2 state-owned hospitals--one in Memphis and one in Knoxville. Twelve SREB states own hospitals that serve as the primary teaching hospitals for their public medical schools.

Three public teaching hospitals have been divested to Non-Profit Corporations (in Florida, Maryland and West Virginia) and one was leased to a for-profit corporation (Louisville). The balance of the public medical schools utilize hospitals that are governed by city, county, district, or authority structures, as well as the Veterans Administration.

Of the 13 private medical schools in the region 10 have teaching hospitals governed by not-for-profit corporations and 3 by public hospital authorities. None of the private universities govern their medical school's principal teaching hospitals. It does not follow however, that these institutions and/or their medical schools do not exert considerable influence on the operations of and clinical services in the teaching hospitals through the structure and composition of the hospital's board.